Minutes of the meeting of the Board of Directors of the Cook County Health and Hospitals System held Thursday, March 28, 2013 at the hour of 8:00 A.M. at 1900 West Polk Street, in the Second Floor Conference Room, Chicago, Illinois.

I. Attendance/Call to Order

Chairman Carvalho called the meeting to order.

Present: Chairman David Carvalho, Vice Chairman Jorge Ramirez and Directors Hon. Jerry Butler; Edward L. Michael; Luis Muñoz, MD, MPH; Heather E. O'Donnell, JD, LLM; Carmen Velasquez; and Dorene P. Wiese, EdD (8)

Present Telephonically: Reverend Calvin S. Morris, PhD (1)

Absent: None

Chairman Carvalho stated that Director Morris was unable to be physically present, but is able to participate in the meeting telephonically.

> Vice Chairman Ramirez, seconded by Director Butler, moved to allow Director Morris to participate as a voting member for this meeting telephonically. THE MOTION CARRIED UNANIMOUSLY.

Director Morris indicated his presence telephonically.

Additional attendees and/or presenters were:

Jorelle Alexander, DMD, MPH – Director of Oral Health
Gina Besenhofer – System Director of Supply Chain Management
Anne Clancy – Chicago Community Oral Health Forum
John Cookinham – System Chief Financial Officer
Krishna Das, MD – System Interim Director of Quality, Patient Safety, Regulatory and Accreditation
Patrick T. Driscoll, Jr. –State's Attorney's Office
Jacqueline Gomez – Cook County Office of Contract Compliance
Susan Greene – System Interim Director of Managed Care
Helen Haynes – System Associate General Counsel
Ram Raju, MD, MBA, FACS, FACHE – Chief Executive Officer
Elizabeth Reidy – System General Counsel
Deborah Santana – Secretary to the Board
John Jay Shannon, MD – Chief of Clinical Integration
Joy Wykowski – Director of Intergovernmental Affairs

II. Public Speakers

Chairman Carvalho asked the Secretary to call upon the registered speakers.

The Secretary called upon the following registered speakers:

1.	Dr. Rahman	Former Employee
2.	George Blakemore	Concerned Citizen
3.	Betty Boles	Vice President, SEIU Local 73
4.	Joanne Tunney	Former Employee, Cermak Health Services of Cook County
5.	Sunny Okoro	Mental Health Specialist, Cermak Health Services of Cook County

II. Public Speakers (continued)

6.	Al Pitts	Former Employee, Cermak Health Services of Cook County
7.	Gregory VanDuan	Mental Health Specialist, Cermak Health Services of Cook County
8.	Dan Boris*	Research Director, SEIU Local 73 (written testimony also provided – Attachment #1)
9.	Charles Williams, DDS*	Concerned Citizen

*provided testimony prior to the conclusion of the meeting

III. Board and Committee Reports

A. Minutes of the Board of Directors Meeting, February 28, 2013

Director Velasquez, seconded by Director Muñoz, moved the approval of the minutes of the Board of Directors Meeting of February 28, 2013. THE MOTION CARRIED UNANIMOUSLY.

B. Minutes of the Quality and Patient Safety Committee Meeting, March 13, 2013

During the presentation of the Minutes, Director O'Donnell indicated that, as the System is moving towards a patient-centered medical home model, she hopes that the subject will be a significant point of discussion in upcoming Quality and Patient Safety Committee Meetings.

Director Michael, seconded by Director Muñoz, moved the approval of the minutes of the Quality and Patient Safety Committee Meeting of March 13, 2013. THE MOTION CARRIED UNANIMOUSLY.

C. Minutes of the Finance Committee Meeting, March 22, 2013

Director O'Donnell, seconded by Director Butler, moved the approval of the minutes of the Finance Committee Meeting of March 22, 2013.

During the presentation of the Minutes, Director O'Donnell indicated that the review by Contract Compliance has not yet been completed for request numbers 6 and 12, under the proposed Contracts and Procurement Items contained within the Minutes; it has been recommended that the Board conditionally approve those two requests, pending completion of review by Contract Compliance.

Director O'Donnell provided additional information relating to the contractual request to execute a contract for interpreter services (request number 15), that was recommended for approval by the Finance Committee. In 2010, the Cook County Board passed a Resolution suggesting that the County not contract with Arizona-based contractors, unless it is critical to the services provided by the County. Interpreter services are critical to the services that are provided by the System; therefore, it was concluded that, based on the results of the Request for Proposals (RFP) process used and the need, execution of this contract is in the best interests of the County. With regard to the subject of interpreter services, Director Velasquez indicated that she hopes that the System will continue its efforts to hire fluent bilingual/bicultural staff.

III. Board and Committee Reports

C. Minutes of the Finance Committee Meeting, March 22, 2013 (continued)

The Board discussed the subject of collection, submission and processing of Waiver applications. Dr. Ram Raju, Chief Executive Officer, stated that 32,000 Waiver applications have been collected. There are three parts to the process: 1) collection of the application; 2) submission of the application to the Illinois Department of Human Services (DHS); and 3) processing/approval of the application by DHS. Susan Greene, System Interim Director of Managed Care, stated that currently, it is taking DHS approximately 32-42 days to process.

Chairman Carvalho noted a previous request made for information regarding a timetable for projected enrollment. Dr. Raju provided this information (Attachment #2); he indicated that this information will be included with the financial report on CountyCare that is presented to the Finance Committee on a monthly basis[1].

The Board discussed the marketing and outreach activities for CountyCare. Joy Wykowski, Director of Intergovernmental Affairs, provided information regarding the activities of The Prairie Group, the vendor selected to provide outreach services. Director Velasquez expressed concerns regarding marketing and outreach activities and how they may not include reaching out/interacting with community groups in terms of intake and enrollment activities. She stated that, in hindsight, what should have been done is some contracting with neighborhood organizations so that they could have done the intake; the enrollment could go much faster and the System's goals could be reached. Dr. Raju stated that he will definitely take that under advisement and pass this on to the vendors, to make sure that they do the proper reaching out to the neighborhood organizations. He noted that the System is receiving approximately 570 applications per day from the various outreaches. There are not enough people involved in the enrollment activities – in order to send the applications to DHS, there are documents that need to be collected from the applicant to submit along with the applications. Eventually it is expected that the administration will be able to free up more people to go and do enrollment in different community forums and different areas; however, the System is simply overwhelmed by the number of applications at the present time. He will take Director Velasquez' comments under advisement and will discuss the subject with the project team that includes those involved with outreach activities. Following that discussion, he will follow-up on the subject with Director Velasquez. Chairman Carvalho noted that a regular feature at the Finance Committee is to get an update on all of the different elements of the CountyCare implementation; he recommended that this subject be included within that update structure in order to receive information on progress that is being made on integrating outreach efforts into community activities[2].

Further discussion took place on the subject of the two contractual requests that are pending review by Contract Compliance. Chairman Carvalho clarified that, by conditionally approving those requests, would that mean that those contracts could not go into effect until review and verification by Contract Compliance has been achieved? Gina Besenhofer, System Director of Supply Chain Management, responded affirmatively. Chairman Carvalho noted that, as previously discussed at the Finance Committee, the Board always has the option, if it is a critical path contract, to approve it conditionally – conditional approval does not grant authority to move forward if Contract Compliance is not achieved, but rather only if it is achieved. Ms. Besenhofer concurred.

Chairman Carvalho indicated that a substitute motion to approve would be in order; the mover and seconder withdrew their motion to approve, so this would be a substitute motion. Director Butler expressed concerns regarding voting to conditionally approve the two contractual items, as Contract Compliance review and verification may or may not happen. Chairman Carvalho stated that the Board has, in the past, granted conditional approval in instances like this, particularly in cases of critical need contracts. When the Board shifted to monthly meetings, rather than meeting every two weeks, in order to try to avoid delays in purchasing for these types of contracts, the Board has granted conditional approval, on a very limited basis.

III. Board and Committee Reports

C. Minutes of the Finance Committee Meeting, March 22, 2013 (continued)

Director Michael, seconded by Director O'Donnell, moved the approval of the minutes of the Finance Committee Meeting of March 22, 2013, with conditional approval of request numbers 6 and 12, subject to completion of review and verification of the two (2) proposed requests by Contract Compliance, under the Contracts and Procurement Items contained within the Minutes. THE MOTION CARRIED.

Director Butler voted NO.

Chairman Carvalho voted PRESENT on request numbers 1 and 2, under the Contracts and Procurement Items contained within the Minutes.

With regard to Contract Compliance, Dr. Raju stated that he has had very good discussions with Jacqueline Gomez, Director of the Cook County Office of Contract Compliance; she has been very helpful in getting some of the waivers in a very quick fashion. He stated that he is looking forward to continue working with her very closely to get this process going. Chairman Carvalho agreed; he noted that the System has always had a good relationship with Contract Compliance, because the Board and administration is committed to meeting the goals. Ms. Gomez provided additional comments. She stated that she has been in her role for almost two months; in those two months she has learned a lot about the System. She stated that she and her staff look forward to continuing to work closely with the System to ensuring participation, particularly with minority and women-owned businesses.

IV. Action Items

A. Contracts and Procurement Items (Attachment #3)

Chairman Carvalho stated that request number 1 is being withdrawn from consideration; that request will be discussed in Finance Committee in greater detail before being brought back before the Board. Ms. Besenhofer provided an overview of request number 2; conditional approval was requested, pending completion of review by Contract Compliance.

During the discussion of request number 2, Chairman Carvalho inquired how different categories of payer are treated, in terms of reimbursement. Helen Haynes, System Associate General Counsel, responded that the contract provides for Cook County to reimburse for uninsured patients cared for off-site, subject to the CareLink Policy, etc.; the insured patients would be billed directly by Cook Radiation Oncology. Chairman Carvalho clarified that these contract dollars provide for the care of the uninsured, because the vendor will receive their reimbursement for the insured patients directly by billing the payer. Ms. Haynes responded affirmatively.

Director O'Donnell, seconded by Director Velasquez, moved the conditional approval of request number 2, subject to completion of review and verification of the request by Contract Compliance. THE MOTION CARRIED UNANIMOUSLY.

B. Any items listed under Sections III, IV, V and VIII

V. Recommendations, Discussion/Information Items

A. Presentation from the Chicago Community Oral Health Forum (Attachment #4)

Chairman Carvalho stated that last month, the Chicago Community Oral Health Forum hosted a luncheon to discuss how to address the issue of inadequate oral health care available to the under-insured and uninsured in Cook County. Following the luncheon, he invited representatives from the Forum to provide a presentation to this Board on the subject. He added that, following the presentation by the Forum, Dr. Jorelle Alexander, the System's new Director of Oral Health, will be making a presentation about her initial assessment of the state of both the System's Oral Health program and her coming plans for the revival of that program under her leadership.

Chairman Carvalho introduced Anne Clancy, Director of the Chicago Community Oral Health Forum, who reviewed the information provided in the presentation.

Chairman Carvalho inquired regarding whether the City of Chicago has a dental program. Ms. Clancy responded that the City of Chicago has shuttered all of their current public health clinics that provide dental care; that happened starting in 2009 and ended in 2011 - all of the Chicago Department of Public Health's dental clinics have been closed. She noted that Chicago has a very robust school-based prevention program, where dentists will go into schools and provide prevention; however, they do not provide any treatment for the caries (dental decay).

Medicaid does not provide preventive care or dental care for oral health in adults. Ms. Clancy referenced information that was reflected in recent surveys. In one survey, it was found that 60% of adults in Chicago visited the dentist last year; 40% did not visit the dentist last year. Survey results also reflect that adults who do not have Medicaid cannot afford dental care, and they do not know where to go to see a dentist; additionally, if they do have access to a clinic they cannot go, because the hours are usually during working hours or times that they have their children.

Director Velasquez provided information on existing dental care services based on her experience at the Alivio Medical Center. She stated that dental services for pediatrics are provided at their Morgan site; they will be provided at the Berwyn site when it opens. The differences in reimbursement opportunities for dental care for adults and children were discussed. Ms. Clancy stated that although Medicaid does not reimburse for oral health services for adults, there are ways to get some reimbursements through sliding-fee scales, etc. for children. She stated that Medicaid currently reimburses fairly well for prevention in children, and at not quite as well a rate for restorative services for children. Treating adults is always a challenge, but there is such a great need. She noted that treating an adult in a dental clinic is much less expensive (60%) than treating an adult in an emergency room with an emergency visit. Additionally, an emergency room visit is not usually a treatment – for example, the patient would get antibiotics, the infection would go away for a while but the source of the infection (typically the tooth) is not removed; therefore, the patient ends up coming back to the emergency room and it becomes a repeat issue. Chairman Carvalho noted that it is better to be doing a dental filling in a clinic, rather than an extraction in the emergency room.

Director Velasquez indicated that the question is whether Cook County Health and Hospitals System can begin to service more adults and children. Dr. Raju stated that everybody has to be involved in this effort - that includes the private dental folks and doctors, hospital systems, Federally-Qualified Health Centers (FQHCs), and the System. There cannot simply be one solution based on the County's System of providing the dental coverage for all adults. Ms. Clancy noted that the Forum is a coalition of sixty organizations that includes the leaders in oral health in the State, including the Chicago Dental Society and the Illinois State Dental Society. She added that organizing this type of effort is something that the Forum could bring together, to get the think tanks together to see what can be done.

V. Recommendations, Discussion/Information Items (continued)

B. Report from System Director of Oral Health (Attachment #5)

Dr. Jorelle Alexander, System Director of Oral Health, presented a report regarding her initial assessment of the state of both the System's Oral Health program and her coming plans for the revival of that program under her leadership. Information reviewed in the report included the following subjects: vision for advancing oral health care; challenges to the oral health safety net; current operations; and recommendations for improvement and maximizing success. The Board reviewed and discussed the information.

In response to a question from Chairman Carvalho regarding evaluation of the hours of service, in order to make it more convenient and accessible for the patients, Dr. Alexander stated that, as reflected in the assessment, the System is limited alike by the locations in which care is provided; that is the biggest limitation, in terms of being able to expand service hours beyond the standard schedule. As the System starts to look at expanding, and expanding existing locations, then an analysis of the needs for those centers can be done, in terms of what is going to work best for the population served at that particular site.

Chairman Carvalho stated that theoretically, preparation of a budget ought to be the opportunity to prioritize what the System should be doing and how it is paid for; in government especially, but probably in all organizations, it tends more to be how to protect what is currently being done. In the past, because there was no internal champion at the System to advocate for oral health, it always suffered. The reason oral health was revived was because, in addition to the System's existing resources, the County Board appropriated additional funding for oral health. There may be programs that only exist because there is somebody who is here who is the champion of them, but in the greater scheme of things, they are not what the System ought to be doing or they are not as important as some of the other things. Given the importance of oral health, as budget activities move forward, he encouraged the administration to keep this in mind and to seek the Board's counsel or support, if needed.

VI. Report from Chairman of the Board

Update on Nominating Committee

Chairman Carvalho provided an update on recent and upcoming activities involving the Nominating Committee of the Board of Directors of the Cook County Health and Hospitals System, regarding the consideration of potential candidates to recommend to the President to fill the current and upcoming vacancies on the System Board. There are three Directors (Michael, O'Donnell and vacancy of Greenspan) whose terms expire at the end of June. Additionally, there is a term expiring in 2014 that is currently vacant (vacancy of Golden).

The Nominating Committee is created by County Ordinance; its members consist of fourteen civic organizations. The Committee had its first meeting of this cycle last week and established a framework for their work. Each organization is going to present several names of potential candidates for consideration; the full Committee will go through their process to narrow that group down to fewer names. Ultimately, their charge is to deliver a slate of potential candidates to the County Board President; following this, the President will present her selection to fill the vacancies from that slate to the County Board for their approval.

Retirement of Helen Haynes, System Associate General Counsel

Chairman Carvalho stated that Associate General Counsel Helen Haynes will be retiring from the System at the end of the month, after twenty-five years of service. He stated that she began at the State's Attorney's Office, and was someone he worked with very closely when he worked at the County's Bureau of Health Services. She also served at the Cook County Department of Public Health; following that, she joined the System. He stated that Ms. Haynes will be sorely missed, as she is an incredibly skilled and devoted professional. Chairman Carvalho and the Board thanked Ms. Haynes for her twenty-five years of service to the County.

VI. Report from Chairman of the Board (continued)

A. Board Education

- **Set Targets Achieve Results (STAR) Report – 1st Quarter 2013** (Attachment #6)

Dr. Krishna Das, System Interim Director of Quality, Patient Safety, Regulatory and Accreditation, provided a presentation regarding the STAR Report – 1st Quarter 2013. Information contained in the presentation included the following: Review of Metrics – Inpatient Services; Outpatient Services; 1115 Waiver/Managed Care; and Shared Services. The Board reviewed and discussed the information.

VII. Report from Chief Executive Officer (Attachment #7)

A. Leadership Goals

This report was received following the adjournment of closed session.

Dr. Raju provided an update on the following subjects: CCHHS and Rush Strategic Partnership; Doctors' Day 2013; and Employee Recognition.

Dr. Raju's report included the recognition of the following individual:

- Dr. Sumeet Bhavsar – Internal Medicine Resident

With regard to the update on the CCHHS and Rush Strategic Partnership, Dr. Raju stated that the current Master Affiliation Agreement with Rush is coming to an end next year. He stated that representatives from Rush requested to extend the Agreement. Dr. Raju's response was that the relationship would need to be different, because it cannot be that medical education drives the patient care; rather, the patient care should drive the medical education. First and foremost, if Rush wants to be the System's academic partner, they have to acknowledge and be a part of a shared vision. That vision is that Cook County will take care of CountyCare patients in a quality, safe and efficient way and excel in patient satisfaction; they have to agree that they will help Cook County to take care of CountyCare patients and acknowledge that part of it. Once Rush agrees that they are going to help the System achieve that vision, the second part of it will be to determine what these patients need as a form of care. Once this is determined, then the decision will be made regarding what services of that care will be provided by the System and what services the System will need from its clinical affiliation partners. The needs of the System's patient population will drive the medical education component. He noted that Dr. John Jay Shannon, Chief of Clinical Integration, has been closely involved in the discussions between Dr. Raju and the leadership at Rush.

Dr. Shannon reviewed the information regarding the overall shared vision concept. He noted that the conversations that the administration will be having with Rush between now and 2014 are going to be centered around the following three major dimensions of the relationship: model of care delivered to the patients that the County serves; clinical coordination of care; and academic affiliation. He noted that the working document of the draft Vision Statement has been provided for the Board's information (included in Attachment #7).

VIII. Closed Session Items

A. Claims and Litigation

B. Update on labor negotiations

This item was taken out of order.

VIII. Closed Session Items (continued)

Director Butler, seconded by Director Muñoz, moved to recess the regular session and convene into closed session, pursuant to the following exceptions to the Illinois Open Meetings Act: 5 ILCS 120/2(c)(**1**), regarding "the appointment, employment, compensation, discipline, performance, or dismissal of specific employees of the public body or legal counsel for the public body, including hearing testimony on a complaint lodged against an employee of the public body or against legal counsel for the public body to determine its validity," 5 ILCS 120/2(c)(**2**), regarding "collective negotiating matters between the public body and its employees or their representatives, or deliberations concerning salary schedules for one or more classes of employees," 5 ILCS 120/2(c)(**11**), regarding "litigation, when an action against, affecting or on behalf of the particular body has been filed and is pending before a court or administrative tribunal, or when the public body finds that an action is probable or imminent, in which case the basis for the finding shall be recorded and entered into the minutes of the closed meeting," and 5 ILCS 120/2(c)(**12**), regarding "the establishment of reserves or settlement of claims as provided in the Local Governmental and Governmental Employees Tort Immunity Act, if otherwise the disposition of a claim or potential claim might be prejudiced, or the review or discussion of claims, loss or risk management information, records, data, advice or communications from or with respect to any insurer of the public body or any intergovernmental risk management association or self insurance pool of which the public body is a member."

On the motion to recess the regular session and convene into closed session, a roll call was taken, the votes of yeas and nays being as follows:

Yeas:	Chairman Carvalho and Directors Butler, Michael, Morris, Muñoz, O'Donnell and Velasquez (7)
Nays:	None (0)
Absent:	Vice Chairman Ramirez and Director Wiese (2)

THE MOTION CARRIED UNANIMOUSLY.

Chairman Carvalho declared that the closed session was adjourned. The Board reconvened into regular session.

IX. Adjourn

As the agenda was exhausted, Chairman Carvalho declared the MEETING ADJOURNED.

Respectfully submitted,
Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXXXX
David Carvalho, Chairman

Attest:

XXXXXXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

[1] Follow-up: Timetable for projected enrollment to be included in the regular updates on the CountyCare implementation provided monthly to the Finance Committee. Page 3.

[2] Follow-up: Updates on progress being made in integrating outreach efforts into community activities to be included in the regular updates on the CountyCare implementation, provided monthly to the Finance Committee. Page 3.

ATTACHMENT #1

LOCAL 73
SEIU
Stronger Together

SERVICE EMPLOYEES
INTERNATIONAL UNION
LOCAL 73
www.seiu73.org

CHRISTINE BOARDMAN
President

MATT BRANDON
Secretary-Treasurer

BETTY BOLES
Vice President

DALE HILLIER
Vice President

TIM MC DONALD
Vice President

TAALIB-DIN ZIYAD
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March 28, 2013

Members of the Board of Directors of the Cook County Health and Hospitals System,

My name is Dan Boris, Research Director at SEIU Local 73.

SEIU Local 73 and the Doctor's Council of SEIU supported, lobbied and advocated for Cook County Health and Hospitals System's proposal for an 1115 Waiver.

We are deeply committed to ensuring the success of the waiver and of Cook County Health and Hospitals system. We are working with Dr. Steve Stabile to transform outpatient Ambulatory (ACHN) clinics into Patient Centered Medical Homes that will provide comprehensive primary care and are trying to work with county administration to establish important training programs for employees there.

However, we are deeply concerned that the health system is neglecting the enrollment of existing patients into its facilities, and instead directing outreach and enrollment activities to steer new patients into Federally Qualified Health Centers instead of our county's sites. If these trends continue, our system (CCHHS) will lose significant funds in 2014.

Specifically, according to documents obtained from the Department of Healthcare and Family Services, "CountyCare has trained over 420 Application Assistors both within the CCHHS system and the FQHCs".

But based on discussions with CCHHS contractors and conversations with our members, it seems that paid contractors of the county have been using waiver funds to train FQHC employees as in-person application assistors at all of their sites. In the county health system, there is ***only one site,*** Stroger/Fantus, where in-person assistors can enroll clients into CountyCare.

This approach is in direct conflict to the goals of our Waiver: to shore up the finances of this health system and to improve the quality of care.

We are ready and willing to work with Dr. Raju and others to ***cross-train health system employees*** as application assistors at all of our clinics. Indeed, according to Automated Health Systems' contract, the Third Party Administrator will staff in-person assistors at "walk-in centers, outlying clinics, and any other requested deployment." From all accounts, this has not been done.

But behind every action, there is a rationale. Susan Greene and Associates, while running the interim office of managed care, also retains six FQHCs as clients, at least according to its website. These clients happen to have been picked to join the CountyCare provider network, and close colleagues of Susan Greene's firm at Health Management Associates have trained these FQHCs' employees as application assistors, while neglecting to train county employees. We urge the health system board of directors to investigate any

potential legal or ethical violations, and any self-dealing that may unduly influence the decisions of the interim office of managed care.

In conclusion, we strongly urge the health system to train county employees as application assistors, and focus outreach efforts to bring new clients to the county health system rather than network providers who already receive a financial incentive for enrolling CountyCare clients.

Thanks for allowing me the time to talk with you today.

ATTACHMENT #2

1115 Status Update

Enrollment

	Initiated Application Target	YTD Total Initiated Applications
November	1,000	1,030
December	4,000	2,873
January	9,000	7,794
February	16,000	17,686
March	25,000	32,000
April	35,000	0
May	46,000	0
June	57,500	0
July	69,000	0
August	80,500	0
September	92,000	0
October	103,500	0
November	115,000	0
Deccember	115,000	0

Denial Rate: 12% Days to Process: 60

Net Revenue

	Budgeted Target	Actual MTD
November	$0	$0
December	$0	$0
January	$0	$0
February	$4,219,600	$0
March	$8,338,733	$0
April	$12,156,467	$0
May	$16,275,600	$0
June	$17,330,500	$0
July	$20,796,600	$0
August	$24,262,700	$0
September	$27,728,800	$0
October	$31,194,900	$0
November	$34,661,000	$0
	$196,964,900	**$0**

Revenue payments expected to begin at the end of February due to the 60 day cycle time from application to approval

ATTACHMENT #3

COOK COUNTY HEALTH AND HOSPITALS SYSTEM
ITEM IV(A)
MARCH 28, 2013 BOARD OF DIRECTORS MEETING
CONTRACTS AND PROCUREMENT ITEMS

Request #	Vendor	Service or Product	Fiscal Impact	Affiliate / System	Begins on Page #
Amend and Increase Contract					
1	Sodexo America, LLC	Product and Service - Food and Nutrition, Environmental and Patient Transportation Management and related services	$7,585,558.40	PHCC, SHCC, OFHC	2
Execute Contract					
2	Cook Radiation Oncology, S.C.	Service - radiation therapy services	$5,771,250.00	SHCC	3

BOARD APPROVAL REQUEST

SPONSOR: Regina M. Besenhofer, Director Supply Chain Mgmt	**EXECUTIVE SPONSOR:** Anthony Rajkumar, Chief Business Officer
DATE: 03/19/2013	**PRODUCT / SERVICE:** Product & Service –Food and Nutrition, Environmental and Patient Transportation Management and Related Services
TYPE OF REQUEST: Amend and Increase Contract	**VENDOR / SUPPLIER:** Sodexo America, LLC, Downers Grove, IL
ACCOUNT 897-450 Stroger Hospital 891-450 Provident Hospital 898-450 Oak Forest Health Center	**FISCAL IMPACT:** Total: $7,585,558.40
	GRANT FUNDED RENEWAL AMOUNT: N/A
CONTRACT PERIOD: 07/01/2011 thru 06/30/2016	**CONTRACT NUMBER:** H11-72-054
X	**COMPETITIVE SELECTION METHODOLOGY:** RFP
	NON-COMPETITIVE SELECTION METHODOLOGY: N/A

PRIOR CONTRACT HISTORY:
Cook County Health and Hospitals System Board of Directors entered into a $19,423,678.76, five year, system-wide management services contract with Sodexo in July 2011. The contract covers many aspects of CCHHS operations, including the purchase of food, management of the retail and patient food service operations, management of environmental services and the purchase of supplies, and the management of patient transportation services and the Morgue. Contract pricing was based on a number of assumptions, including CCHHS staffing levels, patient census information, cleanable square footage and revenue projections from retail food sales.

NEW PROPOSAL JUSTIFICATION:
Since the commencement of the contract, the CCHHS has undergone operational changes and has refined its expectations. At this point, the contract requires revision to conform to the parties' current expectations and to adjust pricing to permit a mutually successful arrangement. Changes include adjustments to the patient day rates, clarification of capital improvements, staffing commitments, and provisions for temporary staffing when these are not achieved, and increased funding for costs related to catering, resident meals, meals for observation patients and pediatric inpatient related food services. It is anticipated that these changes will facilitate a good faith effort to achieve improvements that will be key to enhancing the patient experience. Future amendments will likely be necessary to reflect additional service changes and to facilitate revenue opportunities that could permit contract cost reductions.

TERMS OF REQUEST:
This is a request to amend and increase contract number H11-72-054 in the amount not to exceed $7,585,558.40 commencing on 01/01/2013 and continuing through the remaining contract term of 06/30/2016.

CONTRACT COMPLIANCE HAS FOUND THIS CONTRACT RESPONSIVE? Pending

WITHDRAWN

ATTACHMENTS
CONTRACT COMPLIANCE MEMO: Pending

CCHHS CFO: _____
John Cookinham, Chief Financial Officer

CCHHS CEO: _____
Ram Raju, MD, Chief Executive Officer

Request # 1

Cook County Health & Hospitals System

AS AMENDED
BOARD APPROVAL REQUEST

SPONSOR: Patrick Dunne, M.D., Interim Chair Department of Radiology		**EXECUTIVE SPONSOR:** Claudia M. Fegan, M.D. , Executive Medical Director/Medical Director Stroger Hospital
DATE: 03/22/2013	**PRODUCT / SERVICE:** Service – Radiation Therapy Services	
TYPE OF REQUEST: Execute Contract	**VENDOR / SUPPLIER:** Cook Radiation Oncology, S.C., Chicago, IL	
ACCOUNT 897-260 Stroger Hospital	**FISCAL IMPACT:** ~~$ 5,771,250.00~~ $4,423,387.00	**GRANT FUNDED RENEWAL AMOUNT:** N/A
CONTRACT PERIOD: ~~04/01/2013 thru 03/31/2014~~ 09/11/2013 thru 09/10/2014		**CONTRACT NUMBER:** H13-25-029
X	**COMPETITIVE SELECTION METHODOLOGY:** RFP	
	NON-COMPETITIVE SELECTION METHODOLOGY: N/A	

PRIOR CONTRACT HISTORY:
Cook Radiation Oncology has been the provider for on-site radiation therapy and staffing services at Stroger Hospital since 2009 providing services for patients throughout the Cook County Health and Hospitals System. The Cook County Health and Hospitals System Board approved the current contract with this vendor on 11/18/2011 in the amount of $13,245,532 for a thirty six (36) month period.

NEW PROPOSAL JUSTIFICATION:
This request is to award a separate contract to Cook Radiation Oncology for the off-site services that will be required for a period of approximately twelve (12) month times while the two (2) Linear Accelerators are alternately replaced on the Stroger Campus. It will take approximately six (6) months to deinstall and reinstall each Linear Accelerator. As a result approximately one half of the CCHHS patients (450) receiving these services will need to receive treatment at an off-site location. The award of this contract is the result of an RFP to provide the off-site services. The review panel recommended Cook Radiation Oncology based upon their past history of excellent care and expertise within the Cook County Health and Hospitals System. This will also allow for continuity of the care of our patients. All patients will initially be seen at the Stroger Hospital Campus prior to treatment and based up medical evaluation will either receive treatment on campus or be sent to a service location utilized by Cook Radiation Oncology on the campus of Jackson Park Hospital. We are in the process of evaluating the financials of the current contract with Cook Radiation Oncology to avoid duplication in compensated services and to appropriately adjust the financial terms.

TERMS OF REQUEST:
This request is to execute contract number H13-25-029 in the amount not to exceed of $ ~~5,771,250.00~~ $4,423,387.00 for a twelve (12) month period from ~~04/01/2013 thru 03/31/2014~~ 09/11/2013 thru 09/10/2014.

CONTRACT COMPLIANCE HAS FOUND THIS CONTRACT RESPONSIVE? Pending

ATTACHMENTS
CONTRACT COMPLIANCE MEMO: Pending

CCHHS CBO: _____
Anthony Rajkumar, Chief Business Officer

CCHHS CFO: _____
John Cookinham, Chief Financial Officer

CCHHS CEO: _____
Ram Raju, M.D., Chief Executive Officer

APPROVED

MAR 28 2013

BY BOARD OF DIRECTORS OF THE COOK COUNTY HEALTH AND HOSPITALS SYSTEM

2

COUNTY OF COOK
BUREAU OF FINANCE
OFFICE OF CONTRACT COMPLIANCE
JACQUELINE GOMEZ
DIRECTOR

County Building
118 North Clark Street, Room 1020
Chicago, Illinois 60602-1304
TEL: (312) 603-5502

April 5, 2013

Ms. Gina Besenhofer
System Director Supply Chain Management
Cook County Health & Hospitals System
1900 W. Polk Street
Chicago, Illinois 60612

Re: Contract No.: H13-25-029 / (Execute Contract)
Commodity: Service – Radiation Therapy Services
Department: Radiology – Stroger Hospital
Term: 04/01/13 – 03/31/14

Dear Ms. Besenhofer:

The following bid for the above-referenced contract has been reviewed for compliance with the General Conditions regarding the Minority and Women Owned Business Enterprises Ordinance and has been found to be responsive to the Ordinance supporting an overall 35% M/WBE goal.

Contractor: Cook Radiation Oncology, S.C., Chicago, IL
Contract Amount: $5,771,250.00

M/WBE	Status	Participation	Certifying Agency
Classic X-Ray, Ltd., Schaumburg, IL	WBE	7.36% - Indirect	Cook County
Tribune Products Company, Niles, IL	MBE (8)	11.26% - Indirect	Cook County

Partial Waiver Granted: Cook Radiation Oncology, S.C. has made good faith efforts to meet the MBE/WBE goals and utilize MBE/WBE firms in accordance with the applicable participation.

The Office of Contract Compliance has been advised by CCHHS Purchasing that no other vendors are being recommended for award.

Sincerely,

Jacqueline Gomez
Contract Compliance Director

JG/lar

ATTACHMENT #4

Working Together To Improve Oral Health in Cook County

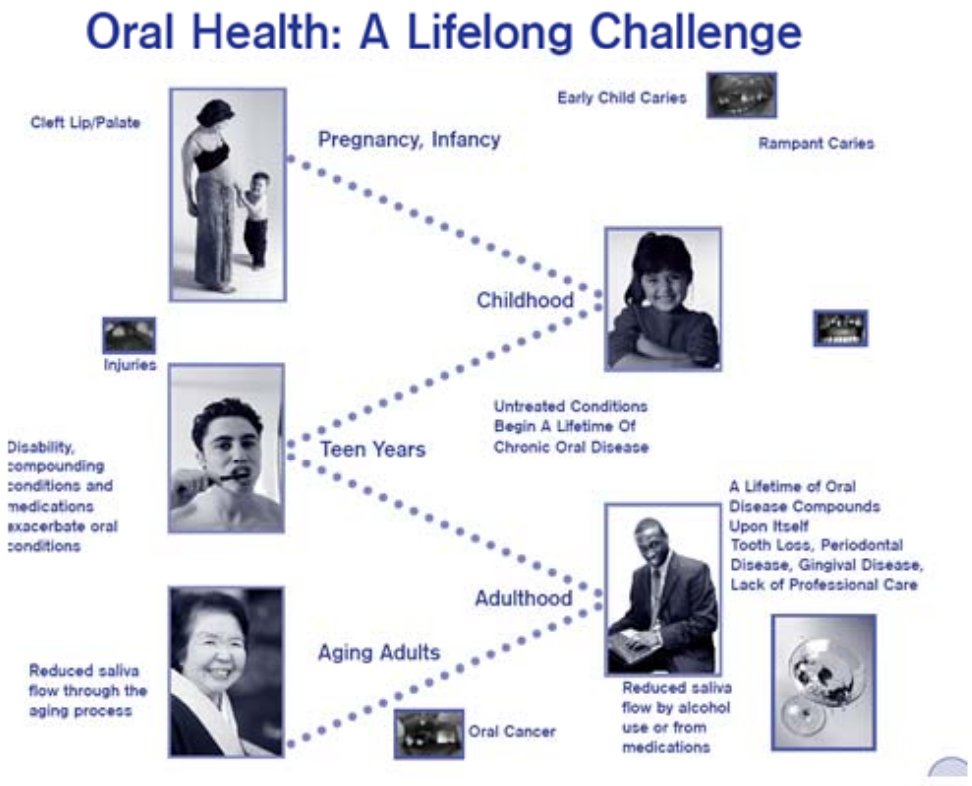
CHICAGO COMMUNITY ORAL HEALTH FORUM

HEARTLAND ALLIANCE | Chicago Community Oral Health Forum

Chicago Community Oral Health Forum

HEARTLAND ALLIANCE | Chicago Community Oral Health Forum

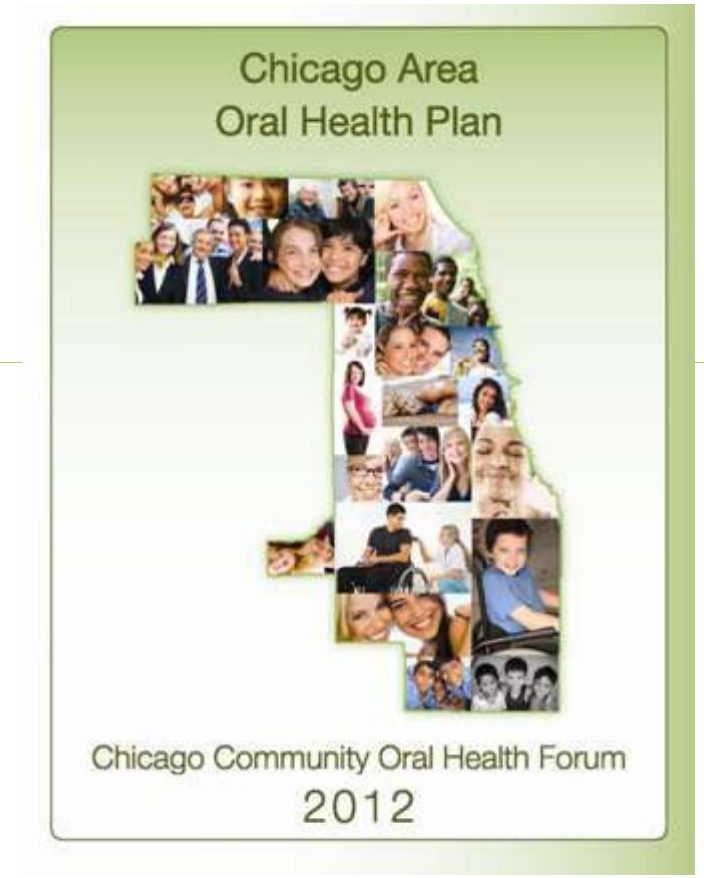
Oral Health Importance



HEARTLAND ALLIANCE | Chicago Community Oral Health Forum

The Burden of Oral Disease in Chicago

Chicago Community Oral Health Forum (CCOHF)
Fall 2011

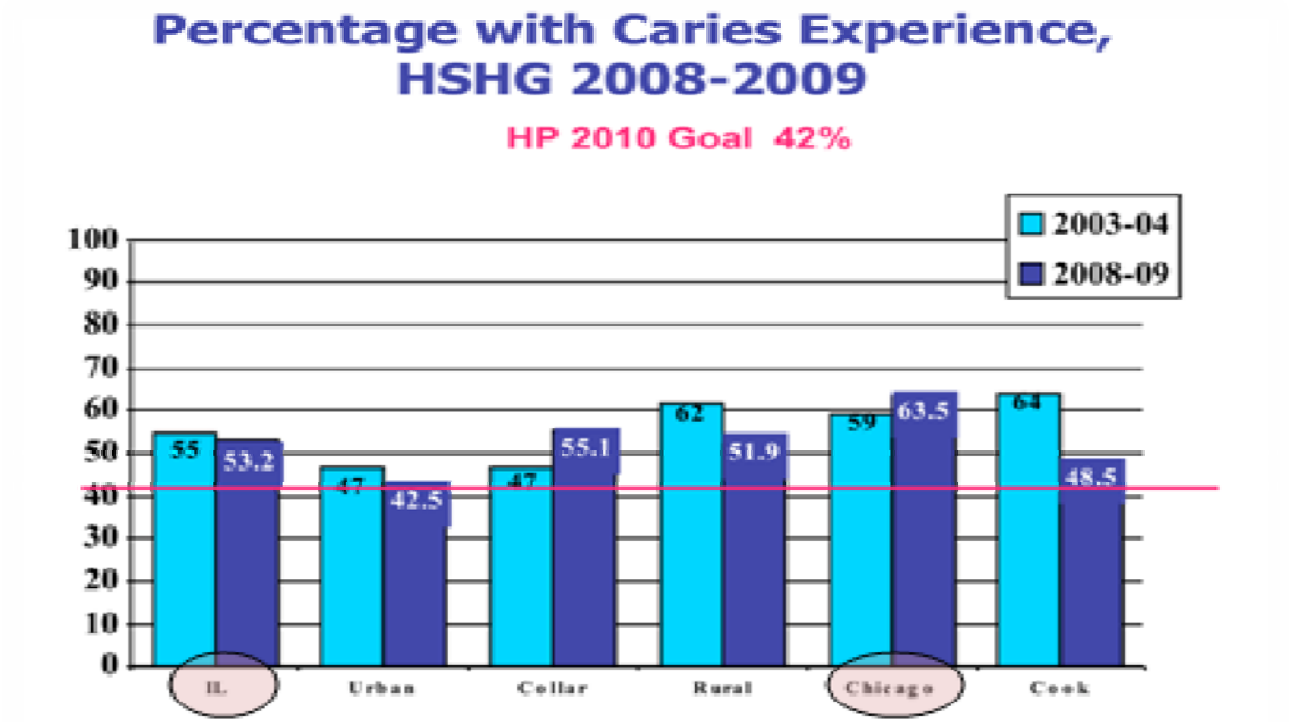


HEARTLAND ALLIANCE | Chicago Community Oral Health Forum

- Four County Clinics
- Only in suburban Cook County
- Limited Hours
- Do not take public aid patients
- Fantus Emergency Clinic

Cook County Dental Program

Oral Health of Children



Chicago 3rd graders have the highest rate of dental caries in the state

HEARTLAND ALLIANCE | Chicago Community Oral Health Forum

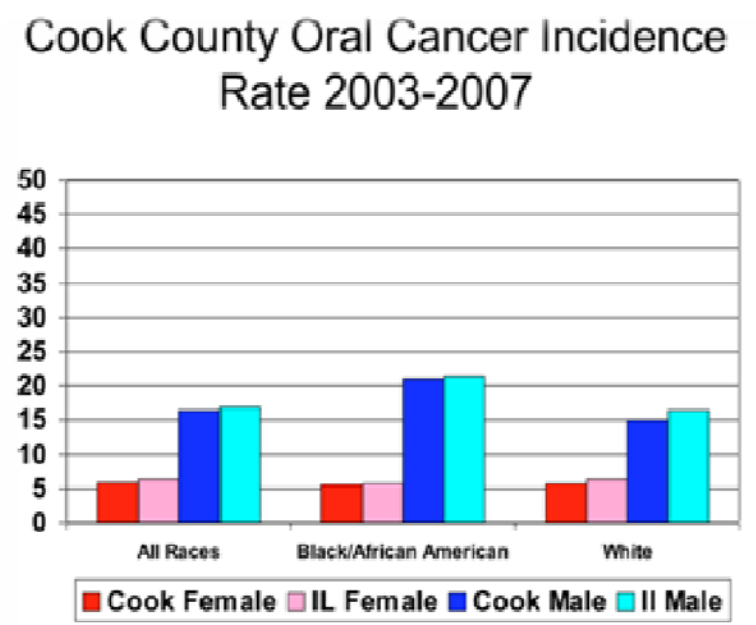
- Tobacco use in IL
  - 11% middle school children
  - 27.5% high school students
- Obesity
- Alcohol consumption
- Methamphetamine use
- Sports-related injuries

Oral Health of Adolescents

- Utilization of preventive dental services [BRFSS (2008)]
  - 60% Chicago adults visited the dentist last year
  - Groups that are less likely to use dental care:
    - Minority groups
    - Low level of education (high school)
    - Low income level ($15-35,000)

- Chicago Community Dental Health Survey:
  - Difficulties that adults have to access affordable dental services:
    - They cannot afford it
    - They don't know where to go
    - Dentists do not take their insurance

Oral Health in Adults



- 1,480 new cases in IL (2008)
- 4th most common cancer in AA males (US)

Tobacco use:

- 19% of adults in Chicago smoke every day (12% IL-US)
- 20% of adults smoke some days (7% IL- 5% US)

Oral Cancer and Tobacco use

HEARTLAND ALLIANCE | Chicago Community Oral Health Forum

- Maximize current infrastructure
- Increase the number of patients treated at Fantus Clinic
- Partner with other dental programs/Public Private Partnerships

The Path to Delivering Critical Dental Care

HEARTLAND ALLIANCE | Chicago Community Oral Health Forum

- Data
- Community Outreach
- School Dental Education Programs

We are here as a resource

HEARTLAND ALLIANCE | Chicago Community Oral Health Forum

How can we work with you?

www.chicagocommunityoralhealthforum.org

HEARTLAND ALLIANCE | Chicago Community Oral Health Forum

ATTACHMENT #5

Creating and Sustaining an Oral Health Program at CCHHS

Cook County Health & Hospitals
Board of Directors Meeting
Thursday, March 28, 2012

Dr. Jorelle R. Alexander, DMD, MPH
Director of Oral Health

The Vision for Advancing Oral Health Care

* Everyone has access to quality oral health care across the life cycle
* Barriers contributing to oral health disparities are eliminated
* Disease prevention and health promotion is a top priority
* Oral health services are provided in a variety of settings
* Providers are competent, compensated and authorized to provide evidence-based care
* Collaborative and multi-disciplinary teams are working across the health care system
* Continuous improvement and innovation are fostered and supported

Institute of Medicine, July 2011

The Challenges to the Oral Health Safety Net

* Increasing demand for care from underserved and disadvantaged populations
* Limited capacity of state and federal agencies and private funders to allocate sufficient resources to support care to these populations
* Safety Nets are struggling to meet existing demand in a financially sustainable manner
* Safety Nets are being asked "How can we do even more with fewer resources?"
* Safety Nets need to rethink and redesign the way they approach their dental programs

Our Current Operations

* **Ambulatory**
  * 4 comprehensive care sites- 2 operatories M-F 8:30-4:30
    * Bridgeview, Ford Heights, Maywood, and Rolling Meadows
* **Core**
  * 1 comprehensive care site - 6 operatories M-F 8:30-4:30
    * Hours currently affected by staffing
* **Cermak**
  * 6 divisions- 12 operatories M-F 7:30-3:30
* **Oral Maxillofacial Residency Program-** Emergency Services Only
  * Calls are taken by ER phone line daily typically 20-25 slots

What Can We Do to Improve?

* Continue to provide emergent care in the appropriate setting
* Eliminate existing disease (still reactive) and Focus on prevention (now becoming more proactive)
* Educate and empower patients and families to better prevent and manage dental disease
* Coordinate care and provide active follow-up for high-risk patients and priority populations to ensure the best outcomes
* Improve efficiency, effectiveness & financial viability of current oral health operations through the adoption of best practices
* Involve the entire health system and community-at-large
* Measure the impact of our work to make sure it's the right work

Maximize Access

* Resolve the internal barriers to maximizing existing capacity (no-shows, scheduling, staffing or equipment)
* Identify opportunities to expand existing facilities (staff, operatories, days and hours of operation)
* Identify opportunities to expand to additional facilities through community collaborations
* Take oral health services outside the walls of the organization
* Create or build on collaborations with others

Maximize Access (Cont'd)

* Integrate with Primary Care
* Improve Oral Health literacy
* Create a culture of accountability and continuous quality improvement
* Identify additional funding sources to ensure financial sustainability
* Create a model community of care
* Engage stakeholders
* Mobilize community resources

ATTACHMENT #6

Star Fiscal Year 2012

Year End Report

Cook County Health and Hospitals System

April 3rd, 2013

Agenda

- Introduction and Overview

- Review of Metrics
  - Inpatient Services
  - Outpatient Services
  - 1115 Waiver/Managed Care
  - Shared Services

Performance Metrics Viewed in Four Activity Areas and Four Domains

	Inpatient	Out-patient	Shared Services	Waiver/ Managed Care
Operational Efficiency	Productivity, cycle time and efficiency measures that track health of core system activities			
Patient Satisfaction	Survey measures that track patient perceptions of experiences with system			
Quality/Health Outcomes	Health measures that track patient and system outcomes			
Financial Stability	Financial measures that track overall financial health of system and individual cost centers			

Introduction- STAR Leadership

Lead	Operating Area
Ramanathan Raju, MD	Leadership
Jay Shannon, MD	Leadership
Tony Rajkumar	Leadership
Claudia Fegan, MD	Medical Director
Kathi Braswell	Outpatient
Gladys Lopez	Human Resources
John Cookinham	Finance
Susan Greene	Managed Care
Bala Hota, MD	Information Technology
Krishna Das, MD	Quality

Inpatient Services

John H. Stroger, Jr. Hospital
Provident Hospital
Cermak Health Services

Inpatient Services – Operational Efficiencies

Indicator	2011 Actual	2012 Actual	2013 Q1 Actual	2013 Target	2013 Q1 Variance
Stroger					
Emergency dept. volume	138,950	140,781	34,352	NA	NA
ED Wait to be seen (minutes)	172	135	117	120	-2.5%
% Left w/o being seen (LWBS)	12.3%	10%	9.5%	8%	1.5%
% of patients with LOS > 7 d		13%	18.2%	12%	6.2%
Provident					
Emergency dept. volume	36,934	36,833	8,685	NA	NA
ED wait to be seen (minutes)	121	145	156	120	30%
% Left w/o being seen (LWBS)	9.8%	10%	11.2%	8%	3.2%
Cermak					
Health Nurse face to face assessment completed (hours)	-	68	92	24	283%

Inpatient Services – Patient Satisfaction

Affiliate/ Indicator	2011 Actual	Q3 Actual	Q4 Actual	2012 Target	Q4 YTD Variance	2013 Target
Stroger						
% Patients 'definitely' recommend this hospital	64%	61%	59%	70%	-11%	70%
Provident						
% Patients 'definitely' recommend this hospital	60%	70%	65%	70%	-5%	70%

Affiliate/ Indicator	2011 Actual	Q4 2012 Actual	Q1 2013 Actual	Q1 YTD Variance	2013 Target
Cermak					
% of grievances responded to in 10 days	73%	95%	95%	0	95%

Inpatient – Quality of Care

Affiliate/ Indicator	Q3 Actual	Q4 Actual	2012 Target	2012 Q4 Variance	2013 Target
Stroger					
Heart failure care measures	95.3%	97.8%	97%	0.8%	97%
Pneumonia care measures	86.4%	85.2%	95.5%	-10.3%	95.5%
Surgical care measures	96.5%	96.8%	98.3%	-1.5%	98.3%
Provident					
Heart failure care measures	95.9%	92.4%	97%	-4.6%	97%
Pneumonia care measures	100%	94.4%	95.5%	-1.1%	95.5%
Surgical care measures	100%	98.9%	98.3%	0.6%	98.3%

Affiliate/ Indicator	Q2 Actual	Q3 Actual	Q4 Actual	Q4 Variance	2013 Target
Cermak					
% patients incarcerated > 120 days with HgA1C < 7%	47.5%	44.0%	51%	+8.5%	42.5%

Inpatient Services– Financial Stability

Indicator	2011 YE	2012 YE	Q1 2013	Q1 2013 Variance	2013 Target
Inpatient Billing					
Inpatient gross days in revenue outstanding	248	142	105	19%	88
No. of inpatient accounts not final billed (DNFB) after 5 days	949	491	429	-	0
DNFB > 5 days ($)		$11.2 M	$11.2 M	-	0

Outpatient Services

Ambulatory and Community Health Network
Ruth M. Rothstein CORE Center
Oak Forest Specialty Care Center
Cook County Department of Public Health

Outpatient Services – Operational Efficiencies

Affiliate/ Indicator	2011 YE	2012 YE	Q1 2013 Actual	2013 Target	Q1 2013 Variance
ACHN					
No. of days to 3rd next available appointment for new patients (GMC)	12	101	104	30	247%
No. of patients referred and waiting > 21 days for gynecology clinic	1,509	1,686	1829	1,200	52%
CORE					
% of new patient visits scheduled within 10 business days	100%	99%	100%	100%	0

Outpatient Services – Quality of Care

Affiliate/ Indicator	2011 Actual	2012 Q3	2012 Q4	2012 Target	2012 Q4 Variance	2013 Target
ACHN						
% of up-to-date vaccinations in children at 24 months	87%	82%	78%	72%	6%	72%
% of diabetics age 18-65 with at least one HgA1C in the last year	92.5%	89%	87%	82%	5%	82%
% of diabetics age 18-65 with HgA1C > 9	22%	21%	24%	< 29%	5%	<29%
CORE						
No. of eligible patients having routine opt-out HIV test	48,163	17,231*	17,943	55,000	21%	NA
% of patients on ART with most recent viral load of < 1000	91%	90%	87%	90%	0%	>90%

*2012 YE 66,309

Outpatient Services– Financial Stability

Indicator	2011 YE	2012 YE	Q1 2013	Q1 2013 Variance	2013 Target
Outpatient Billing					
Outpatient gross days in revenue outstanding	179	126	90	17%	108
No. of unbilled outpatient accounts	64,094	189,136	93,892	-	0
Unbilled accounts ($)	-	$17.3 M	$17.9 M	-	0
CORE					
% of patients receiving HIV meds from CORE pharmacy*	7.76%	6.99%	4.1%	5.9%	< 10%

* Subsidized through County budget; savings of $60 million

Managed Care / 1115 Waiver

Managed Care /1115 Waiver Proposed Performance Metrics Viewed in Four Domains

Operational Efficiency	• % of patients seen by PCP within 7 days of discharge • % of patients who successfully received a welcome call
Patient Satisfaction	• % call center call which are abandoned while on hold • Member complaints by reason for complaint
Quality/Health Outcomes	• % of diabetics with HgA1C < 9% • % of Pap smears done within previous three years in women 21-64
Financial Stability	• Quarterly clinical costs below PMPM • Quarterly revenue meets budget target

Managed Care/ 1115 Waiver Initial Data

Domain	Specific Outcome	Q1 2013 Actual	2013 Target
Operational Efficiency			
	Received welcome call (1st attempt)	22%	100% (for 3rd call)
Patient Satisfaction			
	Calls abandoned while on hold	7%	< 7%

Shared Services

Human Resources
Finance
Information Technology

Shared Services – Human Resources

	Q1 2013
Vacancies Filled	154
1115 Waiver Vacancies Filled	61
Housestaff Processed	NA

Shared Services – Financial Stability

Indicator	2011 Actual	2012 Actual	Q1 2013 Actual	Q1 2013 Target	Q1 2013 Variance
Total cash received from all sources ($M)	632	578.2	101	99	2%
Medicare	67	62.2	13	13	0%
Medicaid	266	132.2	27	34	-21%
Private Payer	27	20.8	5	5	0%
BIPA	131	131.2	-	-	
Physician Billing		6.2	2.4	3.0	-20%
DSH + DSH Retroactive		170.5	38	37	3%
Meaningful Use		9.6	7	2	250%
Medicaid Retroactive		46.9	-	-	

Information Technology

Meaningful Use Indicators*:

Meaningful Use Indicators, 90 day observation period

Measure	Numerator	Denominator	Metric %	Target %
Computerized Order Entry	4808	6272	77%	30%
Use of Electronic Laboratory Results	923218	1062421	87%	40%
Maintain active medication allergy list	6128	6291	97%	80%
Maintain active medication list	5969	6291	95%	80%
Maintain an up to date problem list	5797	6291	92%	80%
Record Advanced Directives	563	763	74%	50%
Record and Chart changes in vital signs	5375	6059	89%	50%
Record patient demographics	6220	6291	99%	50%
Record smoking status	3693	5938	62%	50%
Provide electronic health information of request		No Requests		

*Data from12/2012

Questions & Wrap Up

ATTACHMENT #7

RAM RAJU, MD, MBA, FACHE, FACS
CHIEF EXECUTIVE OFFICER
COOK COUNTY HEALTH AND HOSPITALS SYSTEM
REPORT TO THE BOARD OF DIRECTORS
March 28, 2013

CCHHS AND RUSH STRATEGIC PARTNERSHIP

The Cook County Health and Hospitals System (CCHHS) and Rush University Medical Center (Rush) entered into a Master Affiliation Agreement nearly twenty years ago. That Agreement recognized the value that closer connections would bring to each system, both in academic pursuits and in clinical coordination. Over the ensuing decades, CCHHS and Rush have: established solid training partnerships that enriched the educational experience for medical students, residents, fellows and attending physicians; created new clinical models, like the CCHHS Ruth Rothstein CORE Center, that brought innovation to the care of vulnerable populations; improved the delivery of health care services through collaboration, as evidenced by the evolution of the Rush Emergency Medicine Department as a joint effort; participated together in the development of new methods of coordinating care for defined populations through the Medical Home Network (MHN), which seeks to link and incentivize safety net providers to assure more effective care for Medicaid patients on the south and southwest areas of Chicago; and partnered on promoting such major policy initiatives as the CCHHS 1115 Medicaid Waiver that will have an impact on the overall health of our community.

The ten-year Master Affiliation Agreement between CCHHS and Rush is due to be renewed mid-2014. This timeframe, along with the massive changes in the health care environment occurring in the same time frame, have spurred the leadership of the two systems to come together to reassess the partnership, to identify areas in which the relationship could be strengthened—including and beyond its historic academic focus--to the mutual benefit of both systems.

CCHHS and Rush recognize the value in a close partnership that builds upon two decades of collaboration in meeting the challenges and opportunities inherent in the rapidly changing health care environment. While both systems must develop their own paths, those paths also converge around shared academic missions and around the needs of populations that both systems are committed to serve. The process of transforming the vision of this partnership into programs and initiatives will be one that will require leadership and perseverance as it will be a long and evolving collaboration. Further, the success of the relationship must be judged by both systems as a whole, not as individual components. Finally, the ultimate beneficiaries of this unique partnership will be the populations and communities who rely on CCHHS and Rush for their care and those health care professionals who will be trained in this new environment. Dr. Jay Shannon, our Chief of Clinical Integration is leading this effort with me.

DOCTORS DAY 2013

National Doctors' Day is held every year on March 30th in the United States, a day to celebrate the contribution of physicians who serve our country by caring for its' citizens. The first Doctor's Day observance was March 30, 1933 in Winder, Georgia. Eudora Brown Almond, wife of Dr. Charles B. Almond, decided to set aside a day to honor physicians. This first observance included the mailing greeting cards and placing flowers on graves of deceased doctors. The red carnation is commonly used as the symbolic flower for National Doctor's Day. On March 30, 1958, a Resolution Commemorating Doctors' Day was adopted by the United States House of Representatives. In 1990, legislation was introduced in the House and Senate to establish a national Doctor's Day. Following overwhelming approval by the United States Senate and the House of Representatives, on October 30, 1990, President George Bush signed S.J. RES. #366 (which became Public Law 101-473) designating March 30th as "National Doctor's Day."

Hopefully everyone gets a chance to say this to the physicians who have served for the past year. To say thank you, this year we are celebrating on Friday, March 29th at a luncheon that I will be announcing the Physician of the Year Award for 2013.

RECOGNITION

Dr. Sumeet Bhavsar – Internal Medicine Resident

I received letter from a patient of Dr. Sumeet Bhavsar's telling how great a doctor he is. The patient stated that he was in the hospital and that although it was a very hard time for him and his family, Dr. Bhavsar made it very painless. The patient continued that Dr. Bhavsar was there when he needed to speak to him and always called back within minutes of leaving a voice mail. The patient stated that the doctor's kindness, generosity and flexibility were really appreciated. The letter concluded with patient acknowledging that his English was not perfect but that Dr. Bhavsar was very patient explaining any information. I thank Dr. Bhavsar for his commitment to his patients and for the example he has set for the patient experience.

Cook County Health and Hospitals System
and
Rush University Medical Center

Vision for a Strategic Partnership

3/13

Introduction

The Cook County Health and Hospitals System (CCHHS) and Rush University Medical Center (Rush) entered into a Master Affiliation Agreement nearly twenty years ago. That Agreement recognized the value that closer connections would bring to each system, both in academic pursuits and in clinical coordination. Over the ensuing decades, CCHHS and Rush have: established solid training partnerships that enriched the educational experience for medical students, residents, fellows and attending physicians; created new clinical models, like the CCHHS Ruth Rothstein CORE Center, that brought innovation to the care of vulnerable populations; improved the delivery of health care services through collaboration, as evidenced by the evolution of the Rush Emergency Medicine Department as a joint effort; participated together in the development of new methods of coordinating care for defined populations through the Medical Home Network (MHN), which seeks to link and incentivize safety net providers to assure more effective care for Medicaid patients on the south and southwest areas of Chicago; and partnered on promoting such major policy initiatives as the CCHHS 1115 Medicaid Waiver that will have an impact on the overall health of our community.

The ten-year Master Affiliation Agreement between CCHHS and Rush is due to be renewed mid-2014. This timeframe, along with the massive changes in the health care environment occurring in the same time frame, have spurred the leadership of the two systems to come together to reassess the partnership, to identify areas in which the relationship could be strengthened—including and beyond its historic academic focus--to the mutual benefit of both systems. This document outlines the vision for this re-envisioned partnership and its commitment to improving the well-being of the populations that both systems serve and the quality of the health professionals both train.

Why Revisit the Relationship Now?

Individually, CCHHS and Rush face dramatic changes in the organization, financing and delivery of care as the Affordable Care Act (ACA) moves toward implementation in 2014. New federal regulations are emphasizing performance and accountability by providers from the perspectives of quality and cost. Medicare has begun applying financial penalties for hospital readmissions and is making differential payments to providers based on

quality—and more of the same is expected from private insurers. The Centers for Medicaid and Medicare Services (CMS) is sending clear messages that they will be paying for the *value*, not merely the *volume*, of services rendered for those covered by both Medicaid and Medicare. Costs will need to be pulled out of the delivery of care, necessitating a hard look at duplications and unnecessary expenditures. Global metrics will need to be established to track the "triple aim" of reducing cost, increasing quality of the patient experience and enhancing health status and these metrics will need to be documentable and focused on clear targets, such as creatively and aggressively addressing chronic illness and end-of-life care. States, including Illinois, are exploring new avenues for directing Medicaid enrollees into managed care arrangements in order to contain costs. These expectations will be the same for all health care systems, public and private.

To meet these new demands, health care systems need to broaden their traditional acute inpatient focus, which is often episodic and uncoordinated care toward a stance that emphasizes a high quality of serves coordinated across the entire continuum of the delivery system – from patient outreach for preventive care to hospital post-acute care with the full spectrum of support in between. New approaches to workforce development must be implemented in order to support this changing healthcare paradigm, particularly in the areas of primary care, care management across levels of service and alternatives to institutionalization for both acute and post-acute treatment. Partnerships must be developed to maximize coordination and minimize duplication of services—as unnecessary cost must come out of the system. Innovative approaches to improve the health of whole populations—not simply individual patients--must be developed, implemented, and demonstrated. Systems and technologies must be established to share information about patient care, and at least equivalent energy and resources must be invested in keeping people well as is now spent on rescuing those who are very sick.

Both CCHHS and Rush are well underway in the process of addressing all of these issues individually. Still, there is a unique opportunity in identifying those areas where the two system strategies intersect and specific targets for where the two systems can be more effective—and innovative—together. Developing a highly effective and efficient delivery system for the populations that rely on public coverage and committing to a joint educational program that trains health care workers in the new delivery system models of the future shape the elements of the priorities stated below as CCHHS and Rush now embark on the creation of a strengthened and committed collaboration. Further, the two systems have a unique opportunity to study the effect of different approaches to healthcare delivery interventions meant to collaboratively meet the triple aim. This health services research would be enormously valuable to others around the country as they seek new models.

What are the Elements of the New Partnership?

CCHHS is one of the largest public health systems in the United States and a critical component of the health care safety net for Chicago and its suburbs. It has a long and storied commitment to producing health care providers who emerge from their training

possessing a disposition to a lifelong commitment to serving underserved populations and communities. Rush is a large private academic medical center with a focused health sciences university. The main campuses of these two systems are adjacent to each other. The successful 20-year history of collaboration between these two organizations provides an opportunity to address today's challenges in ways to maximally utilize the resources and attributes of both.

The vision for the enhanced partnership between Rush and CCHHS will have the following components: 1) Rush collaboration with CCHHS in a model of care for publicly-financed populations, including Medicaid enrollees, the uninsured, those dually-eligible for Medicaid and Medicare, and, perhaps, public employees; 2) collaboration between the two systems to develop clinical linkages that minimize duplication and grow new centers of excellence, particularly for vulnerable populations and communities, and; 3) the establishment of a new academic affiliation that spans all levels of clinical training of varied types of health professionals, reflects the changes in the health care environment in the education of new health care professionals and explores opportunities for collaboration in clinical investigation.

New Model of Care

The ACA is expected to expand Medicaid in Illinois to cover hundreds of thousands of additional people; still, there will be hundreds of thousands that may remain uninsured. It is, therefore, imperative for CCHHS and Rush to have strategies to address both the opportunities and challenges in this new coverage environment and it makes sense for these strategies to coincide. Cook County has been approved by the federal government to implement a Medicaid Waiver that allows CCHHS to expand Medicaid coverage now to those who are likely to be covered by Medicaid when ACA is implemented in 2014. It provides time and support to CCHHS efforts to transform their delivery of care, building on their vast experience and expertise. Many of those who are eligible to be covered by the Waiver program—CountyCare--are currently being served within the County system now; thus, it is important to enroll them and assign them a primary care provider as early as possible so that CCHHS will be reimbursed for that service.

CCHHS has entered into relationships with other primary care providers to assure that there is enough capacity to assure that CountyCare enrollees are promptly empaneled into a medical home. That primary care capacity will need to grow quickly to most fully take advantage of the Waiver and to assure that the CountyCare patients have an experience that will result in their continued enrollment with the CCHHS system when they convert to Medicaid or a subsidized insurance exchange product in 2014. CCHHS is aggressively working to transform its primary care clinics into Patient Centered Medical Homes (PCMH), to assure the most effective utilization of specialty care so as to assure access of this expanded primary care population to needed services, and to establish a care management infrastructure. Many of these initiatives will take time, however, and establishing adequate primary care capacity is an immediate and critical priority. In

addition, CountyCare patients will need access to the full continuum of healthcare services, including behavioral health and care for individuals with substance use disorders, some of which are in short supply within CCHHS.

As Rush has seen a continuing growth in the number of Medicaid and uninsured patients entering its system, it is clear that there is a need for primary care medical homes for many who, upon discharge from the Rush Emergency Department or inpatients beds, have no place to be referred. The capacity for primary care care within the Rush system is limited. Further, Rush has entered into several initiatives focused on the management of Medicaid patients (i.e., MHN), the transformation of Rush primary care to PCMH, and the development of a new workforce model to support the broader approach to health care delivery. These areas of focus, along with the Rush need for a partner to work together to generate the capacity to provide "homes" for those using its emergency services because they have no other option, make the potential for a productive collaboration with CCHHS one that deserves significant priority and attention.

In order to purse the development of a new model of care for the Medicaid, uninsured and other publicly-funded populations, CCHHS and Rush agree to:

- begin immediately—as a critical and mutual priority-- to determine options for collaboration between the two systems that will increase the primary care capacity for CountyCare enrollees;

- collaborate immediately on all potential efforts to enroll all eligible individuals into CountyCare;

- integrate current efforts at workforce development to build primary care capacity using medical home teams, consistent demonstrated best practices;

- identify sustainable options for Rush to provide outpatient specialties and inpatient services to CountyCare patients in order to accommodate referrals for services in which CCHHS has difficulty appropriately meeting patient demand and which fulfill Waiver requirements;

- create mechanisms to link eligible uninsured patients in the Rush system (and, in 2014, Medicaid patients without a primary care provider) into CountyCare;

- jointly determine mechanisms for utilizing the Medical Home Network to support the CountyCare model; and

- enter into discussions about the longer term CountyCare model for managing the care for patients covered by public programs, and the potential for Rush's partnership in the new model.

Clinical Collaborations

Between Rush and CCHHS, there are clinical services that both systems deliver well, those in which one or the other system has more expertise, those that neither provides as well as they should and those that are not provided at all in either system. Because of the two systems' geographic proximity, twenty year interaction, history of building new models (i.e., the CORE Center) and lack of a competition for markets, engaging in clinical collaboration to build better care makes sense. In addition, the changes in the health care environment require assuring quality of services provided and innovating to take costs out of the system. This is an opportune time to systematically explore options for clinical collaborations, particularly in areas in which there has been a positive history between the two systems.

In order to initiate the further development of clinical collaboration between the two systems, CCHHS and Rush agree to:

- build on the immediate commitment to collaborate on the development of new primary care capacity in the CCHHS system and develop a longer term plan for increasing primary care providers (including physicians, Physician Assistants, Nurse Practitioners) and a coordinated workforce to support them;

- jointly evaluate all current clinical activity in both systems for opportunities to collaborate to help meet both individual and collective missions and base that evaluation on the tenets of the "Triple Aim"—increased quality, enhanced overall health status for defined populations and lower costs;

- commit to "pulling the costs out" of both systems by, wherever feasible, collapsing duplicative services, particularly in the areas of high-end diagnostics and other services where redundancy is obvious and where resources could be better directed to filling gaps in the continuum of care required for populations that both systems serve;

- target clinical areas for collaboration, consolidation or growth between the two systems, focusing on the needs of the defined population of publicly supported enrollees in CountyCare (including those that will remain uninsured and those that will be added over time); and

- set priorities for clinical collaboration based on the clinical and financial sustainability of such arrangements, establish a timeline for action and monitor these actions to assure that transformation occurs.

Academic Affiliation

Both institutions acknowledge that CCHHS provides a critical educational setting for Rush and that the affiliation has brought significant benefit to CCHHS. As the renewal of the ten-year Master Affiliation Agreement approaches, it is important to—at the highest levels of system and clinical leadership—evaluate areas in which the agreement could be further strengthened, the "favored partner" status emphasized, new opportunities developed and the changes in the health care environment recognized and accommodated. Further, it is an important time to review those programs for which collaborative undergraduate, residency, and fellowship training should be continued, enhanced, terminated or initiated. In addition, both CCHHS and Rush see great potential in broadening the traditional academic affiliation to include the entire Rush University. Training opportunities for the College of Nursing and the College of Health Sciences will have mutual benefit as Rush students of all kinds gain unique clinical exposure and CCHHS helps to develop a future workforce to serve its mission. Finally, attention must be paid to assuring that the focus of the CCHHS-Rush academic relationship is rooted in and supportive of meeting the clinical needs of those populations and patients that CCHHS is committed to serve.

In order to build a new and expanded academic affiliation between the two systems, CCHHS and Rush agree to:

- draft a new Master Affiliation Agreement during 2013 that broadly states the principles for the continued academic affiliation, the extension of that affiliation to include all of Rush University and recommits CCHHS and Rush as primary affiliates for another ten years;

- review all current department/division sub-agreements based upon a mutually agreed upon set of criteria that assesses the degree to which the sub-agreement is aligned with overall system principles;

- assess the degree to which the agreements in place since 1994 have strengthened these stated missions (e.g. by identifying the number of Rush medical students that have entered residency training in CCHHS or integrated residencies programs; the number of current CCHHS medical staff that graduated from a Rush or integrated training program, the number of CCHHS medical staff with a Rush Medical College (RMC) faculty appointment or serving on RMC committees, etc);

- establish quality and safety metrics that would be built into all sub-agreements and utilized in evaluating the effectiveness of the agreement;

- assess the extent of CCHHS patients involved in Rush-based clinical investigation and identify opportunities for CCHHS patients to receive enhanced care by virtue of participation in clinical trials;

- identify additional training opportunities with the inclusion of strategies (e.g., providing tuition assistance or loan repayment in exchange for a commitment of a trainee to work in an area of need for a period of time after graduation) to meet the ever changing workforce demands;

- extend the academic affiliation into areas of support of efforts designed to achieve the Triple Aim (e.g., a health services research program focused on patient centered outcomes as a component of a robust chronic disease management program that will be essential for managing complex patients in both systems); and

- assure that the process of the negotiation, implementation and monitoring of the Master Affiliation Agreement and all of the sub-agreements includes both system and clinical leaders to assure broad adherence to the vision of the partnership of the two systems and the clinical and academic integrity of each program.

Ongoing Strategic Planning and Implementation

The leadership of both CCHHS and Rush are committed to a continuous process of assessment of efforts in all three areas—model development, clinical collaboration and academic affiliation—discussed above. The process, oversight and milestones required to make this partnership come to life will be clearly articulated and closely monitored. All initiatives will be reviewed for relevance to the opportunities and challenges inherent in national health reform implementation, State innovations in delivery system and payment methodology, and, most important, the effectiveness in meeting the health care needs of the populations and communities that both systems have come together to serve.

Conclusion

CCHHS and Rush recognize the value in a close partnership that builds upon two decades of collaboration in meeting the challenges and opportunities inherent in the rapidly changing health care environment. While both systems must develop their own paths, those paths also converge around shared academic missions and around the needs of populations that both systems are committed to serve. The process of transforming the vision of this partnership into programs and initiatives will be one that will require leadership and perseverance as it will be a long and evolving collaboration. Further, the success of the relationship must be judged by both systems as a whole, not as individual components. Finally, the ultimate beneficiaries of this unique partnership will be the populations and communities who rely on CCHHS and Rush for their care and those health care professionals who will be trained in this new environment.